Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301VISTA ROAD
PASADENA, TX 77504

Respondent Name
SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-06-7845-01

MFDR Date Received
AUGUST 21, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier only denied payment via ANSI payment codes "W10 for date of service September 09, 2005 and "W12" for the date of services of October 21, 2005 for the disputed items .. Carrier Representative Christina Horvath verified compensable injury as the cervical and right shoulder. Ms. Horvath failed to inform healthcare provider of unresolved extent, compensability or liability issue when healthcare provider called to verify worker's compensation claims and pre-authorization verified. After initial/request for reconsideration receipt of medical bill for date for service October 21, 2005 Carrier provided code "W12". Specifically, the Carrier did not attach a PLN 11 (TWCC-21), they are basing denial of reimbursement on."

Amount in Dispute: $15,999.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As evidenced by the attached documentation, the Respondent denied the services at issue per Extent of Injury … As issues of compensability exist, this matter is not ripe for resolution before the Medical Review Division. Please note this compensability issue was noted on the preauthorization approval dated January 5, 2006. The Respondent respectfully requests this matter be abated until such time as final disposition is reached."

Response Submitted by: Harris & Harris Attorney At Law

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 09, 2005 and October 21, 2005	Outpatient Hospital Services	$15,999.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, 27 *Texas Register 12282* amended effective January 1, 2003, sets

forth general provisions regarding dispute of medical bills.

2. 28 Texas Administrative Code §133.307, 27 *Texas Register 12282* amended effective January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1, 16 *Texas Register* 2876 effective June 7, 1991, sets out the procedures for requesting and setting a Benefit Review Conference.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 04, 2005, November 21, 2005, November 22, 2005 and January 05, 2006

   - 510 – Payment determined
   - W10 – Payment based on fair & reasonable methodology
   - W11 – Entitlement to benefits. Not finally adjudicated
   - W12 – Extent of Injury. Not finally adjudicated

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. Per 28 Texas Administrative Code §133.305(a)(2) Medical Fee Disputes—Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines). The dispute is resolved by the commission pursuant to commission rules, including §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute).

   Per 28 Texas Administrative Code §133.307(e)(2)(D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission.

   The Respondent submitted a PLN11 dated September 08, 2005 disputing "the alleged injury to the low back. This injury did not occur within course and scope of employment. The claimant has not reported an on the job injury regarding the condition." and another PLN11 dated October 13, 2005 disputing "the claimant was not injured in the course and scope of his employment as these findings are documented 2 months before the alleged injury of 7-7-05."
2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim has been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		3/1/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.